

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155767	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/09/2015
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NAME OF PROVIDER OR SUPPLIER  SPRINGHURST HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 628 N MERIDIAN RD GREENFIELD, IN 46140
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K 0000  Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 09/09/15</p> <p>Facility Number: 005954 Provider Number: 155767 AIM Number: 201068810</p> <p>At this Life Safety Code survey, Springhurst Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of type V (111) construction and was fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in all resident sleeping rooms. The healthcare portion of the facility has a capacity of 74 and had a census of 62 at the time of this</p>	K 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 0011 SS=F Bldg. 01	<p>visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.</p> <p>Quality Review completed on 09/14/15 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 18.1.1.4.1, 18.1.1.4.2</p> <p>Based on observation and interview, the facility failed to provide a two hour fire rated separation in 1 of 1 two hour fire rated wall between the Health Center and the assisted living occupancy with firestopped fire barrier penetrations. This deficient practice could affect all healthcare residents in the event of a fire in the fire barrier located above the kitchen, which extends above the ceiling along the main dining room to the Service Hall.</p> <p>Findings include:</p> <p>Based on observation on 09/09/15 at</p>	K 0011	<p>All penetration to firewalls within the attic of the Health Center and the attic of the Assisted Living were recaulked by Director of Plant Operations. Residents are no longer in potential risk now that smoke cannot penetrate to their room or hallway. The Director of Plant Operations will audit any contractor's work to ensure that any penetrating holes to smoke barriers and firewalls will be satisfactorily caulked upon completion of work and make adjustments as needed. The Director of Plant Operations will report results of any smoke barrier and firewall work activity through monthly Quality</p>	09/10/2015			

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K 0025 SS=E Bldg. 01	<p>12:45 p.m. with the director of plant operations, the fire barrier wall, located at the attic access panel in the kitchen, had a eight, one half inch to one inch gaps around electrical conduit and sprinkler piping penetrations not fire stopped through the fire barrier wall and three, three inch electrical conduits open with no fire stopping on both sides of the fire barrier wall. This was verified by the director of plant operations at the time of observation and acknowledged at the exit conference on 09/09/15 at 1:50 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3</p> <p>Based on observation and interview, the facility failed to ensure 2 of 6 attic smoke barriers were maintained to provide a one half hour fire resistance rating. This deficient practice could affect all residents who reside in the Health Care Center portion of the facility.</p>	K 0025	<p>Assurance meetings on an ongoing basis. The Director of Plant Operations and the Executive Director are responsible to maintain overall compliance.</p> <p>All penetration to smoke barriers within the attic of the Health Center and the attic of the Assisted Living were recaulked by Director of Plant Operations. Residents are no longer in potential risk now that smoke</p>	09/10/2015

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K 0029 SS=E Bldg. 01	<p>Findings include:</p> <p>Based on observations with the director of plant operations on 09/09/15 during a tour of the attic smoke barriers from 12:30 p.m. to 1:20 p.m., the following attic smoke barriers were not fire stopped;</p> <p>a. The 400 Hall attic smoke barrier wall had a three inch circular area of drywall missing in the center of the wall and three, three inch electrical conduit penetrations not fire stopped.</p> <p>b. The Health Care Center Hall to Administration Hall attic smoke barrier wall had three, one half inch gaps around electrical conduit and sprinkler water pipe penetrations not fire stopped.</p> <p>The 400 Hall and Health Care Center Hall to Administration Hall attic smoke barrier walls not fire stopped and missing drywall was verified by the director of plant operations at the time of observations and acknowledged by the director of plant operations at the exit conference on 09/09/15 at 1:50 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier,</p>		cannot penetrate resident room or hallway. The Director of Plant Operations will audit any contractor's work to ensure that any penetrating holes to smoke barriers and firewalls will be satisfactorily caulked upon completion of work and make adjustments as needed. The Director of Plant Operations will report results of any smoke barrier and firewall work activity through monthly Quality Assurance meetings on an ongoing basis. The Director of Plant Operations and the Executive Director are responsible to maintain overall compliance.	

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K 0144	<p>with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1</p> <p>Based on observations and interview, the facility failed to ensure 1 of 4 corridor doors to combustible storage rooms over 50 square feet was provided with self closing devices which would cause the doors to automatically close and latch into the door frames. This deficient practice could affect 48 residents in the Health Care Center who use the main dining room, located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 09/09/15 at 10:30 a.m. with the director of plant operations, the kitchen food storage supply room, which measured one hundred eighty square feet and stored thirteen shelves of combustible cardboard boxes of dry food products, lacked a self closing device on the door. This was verified by the director of plant operations at the time of observation and acknowledged by the director of plant operations at the exit conference on 09/09/15 at 1:50 p.m.</p> <p>3.1-19(b) NFPA 101</p>	K 0029	<p>Director of Plant Operations readjusted the hinge side of the door frame within dietary pantry area with larger screws allowing door closures to function properly. The Director of Plant Operations toured the campus to confirm this is the only door that did not latch properly. Therefore residents were no longer affected. The Director of Plant Operations will monitor to ensure that work orders are given immediate attention regarding improper fitting door frames on an ongoing basis. The Director of Plant Operations will report through the monthly Quality Assurance meeting of any repair work to doors that do not latch properly. Director of Plant Operations along with Executive Director are overall responsible to see that compliance is maintained.</p>	09/22/2015

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SS=F Bldg. 01	<p><b>LIFE SAFETY CODE STANDARD</b> Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all</p>	K 0144	The generator was being tested weekly per regulations, however the calculations were not documented. The Director of Plant Operations or designee will run the generator under load, calculate the math and log monitoring results on generator chart monthly. Documentation and math calculations will be conducted and maintained within the generator chart. The Director of Plant Operations will be conducting this calculation on every load test and noted on generator chart and will review monthly in Quality Assurance meeting on an ongoing basis to assure resident services will not be interrupted due to a power outage. The Director of Plant Operations and Executive Director maintains overall responsibility for ongoing compliance.	09/14/2015

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	<p>residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on interview and review of the Weekly Generator Load Test Log with the director of plant operations on 09/09/15 at 9:20 a.m., the Weekly Generator Load Test Log for the past year dating from 08/24/14 to 08/31/15 listed a weekly load test of the emergency generator and included the amperage listed for the three branches of power output from the emergency generator but lacked a percent of load. Based on an interview with the director of plant operations on 09/09/15 at 9:45 a.m., the corporate director of plant operations recently sent each facility a letter indicating percent of load is required for the weekly load test log and the percent of load calculation will be implemented starting for the month of October 2015. The lack of the Weekly Generator Load Test Log indicating a percent of load was verified by the director of plant operations at the time of record review and interview, and acknowledged by the director of plant operations at the exit conference on 09/09/15 at 1:50 p.m.</p> <p>3.1-19(b)</p>			